THE GRIFFIN HOSPITAL
BUSINESS OFFICE
STANDARD OPERATING POLICIES

SUBJECT: FREE BED FUNDS/UNINSURED PROCESS/FREE CARE ASSISTANCE

EFFECTIVE DATE: 1/2010 SUPERCEDES: 10/2008

RESPONSIBLE DEPT: Business Services APPROVED BY: James J. Mayle
Administrator

POLICY:

The following policy represents Griffin Hospital's policies and procedures for Free Bed Funds, Uninsured Patients, and Free Care Assistance. All three policies identify funds available for patients having services provided at Griffin Hospital who do not have any type of medical insurance on service date.

PROCEDURES:

Free Bed Funds:

1. Griffin Hospital has published a Free Bed Pamphlet that is located in all patient registration work stations. The pamphlet is outlined in both English and Spanish (see attached sample).

2. The Free Bed Pamphlet is available to all patients admitted to or registered at Griffin Hospital.

3. The pamphlet identifies to the patients the Griffin Hospital Free Bed Funds and the criteria for qualifying for the funds. Free Bed Funds available are:

   - The Eno Fund: an applicant must be a worthy Protestant woman over 60 years old and reside in the town of Ansonia, Derby or Seymour.
   - Pine Trust: available to indigent patients of Griffin Hospital who reside in the City of Ansonia.
   - DN Clark Fund: available to Shelton residents proving financial hardship.

4. To apply for Free Bed Funds, the patient will meet with the hospital Financial Advisor to complete the Free Bed Fund Application.

5. All patients who are seen by the Financial Advisors are required to sign off on the Free Care/Free Bed Informational Letter (attached).

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SUBJECT: FREE BED FUNDS/UNINSURED PROCESS/FREE CARE ASSISTANCE

6. A monthly report will be maintained for each Free Bed Fund by the Collection Supervisor. The month end report will identify the following:

   - total patients who applied for the Free Bed Fund.
   - determination of the Free Bed Fund application process
   - total dollar amount applied toward each of the Free Bed Funds
   - total balance remaining in each Free Bed Fund

A quarterly update of the status of all Free Bed Funds will be provided to the Vice President, Finance.

Uninsured Patient Procedure

1. The patient is registered by the Admitting Registrar who will identify the patient as having no medical insurance (self pay).

2. The patient will be given a Financial Assistance Pamphlet that will identify all Griffin Hospital Free Care assistance programs. The pamphlet also includes hospital contacts for patients seeking State welfare, Saga (City welfare), or other State programs.

3. Patients who register as having no medical insurance with account balances over $3,000 will be referred to the hospital Eligibility Worker. The patient will be seen or contacted by phone within 24 hours of admission. If the Eligibility Worker is unable to ensure this requirement, a Financial Advisor will take the necessary steps to fulfill this requirement. All accounts under $3,000 will be referred to the hospital Financial Advisors.

4. The hospital Eligibility Worker will complete a financial screening for those patients seeking Title 19 eligibility and for the uninsured status.

5. The hospital Eligibility Worker will identify all patients meeting the State/Saga and Husky program criteria. For patients meeting the criteria, the application process will be completed and all paperwork forwarded to the appropriate State department for processing.

6. The patients who do not meet the criteria for the State/Saga/Husky programs will be referred to the hospital Financial Advisor.

7. The Financial Advisor will begin a review to determine if the patient meets the uninsured criteria identified in Public Act 03-266. A letter will be sent to the patient requesting the patient to verify that they do not have medical insurance as identified during their hospital registration process. The letter will also request additional patient information regarding the patient's income if necessary. The criteria the patient must meet as identified in Public Act 03-266 are as follows:

   - patient's income, based on family size, falls under 250% of the poverty income guidelines (see attached poverty income guideline scale).

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THE GRIFFIN HOSPITAL
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SUBJECT: FREE BED FUNDS/UNINSURED PROCESS/FREE CARE ASSISTANCE

- hospital has made a full determination as to the status of the State/Saga/Husky programs (if applicable)

- all Griffin Hospital Free Bed funds have been reviewed and determined non-applicable for the patient in review

8. If the patient responds to the letter sent out by the Financial Advisor, this will begin the application process for the verification of the uninsured patient status. The following information will need to be finalized with the patient in order for the uninsured determination to be made:

   - proof of patient income and family size
   - hospital has made a final determination as to the status of the State/Saga/Husky programs (if applicable)
   - verification of all Free Bed Funds being reviewed with the patient

9. Upon determination that a patient meets the outlined criteria, the patient will be classified as follows:

   - Uninsured Status; the patient's account will be taken from total gross charges and reduced to cost by applying factor supplied annually by OHCA.
   - The patient will be informed of this decision and will be sent a copy of their bill which will reflect the balance at reduction
   - The patient will be advised of the balance that is due and payable.

10. The Financial Advisor will contact the patient to accomplish the following:

    - attempt a payment arrangement with the patient on the remaining balance
    - if the patient identifies to the Financial Advisor that they cannot afford the remaining balance, an application for Free Care assistance will be completed (see Free Care Assistance below)

11. If a patient applies for Free Care Assistance, the Financial Advisor will make a decision on Free Care eligibility based on the patient's family size and income. Free care will be offered based on the Griffin Hospital Free Care assistance sliding scale (see attached sliding scale).

12. The Financial Advisor will advise the patient of the free care determination which will be applied to the patient's remaining balance.

13. The Financial Advisor will complete all appropriate logs with the decisions and amounts.

Free Care Assistance:

1. Any patient requesting financial assistance in paying their Griffin Hospital bill can apply for the Free Care Assistance Program by contacting the hospital's Financial Advisory staff.

THE GRIFFIN HOSPITAL
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STANDARD OPERATING POLICIES

SUBJECT: FREE BED FUNDS/UNINSURED PROCESS/FREE CARE ASSISTANCE

2. The Financial Advisor will be contacted by the patient to complete the Free Care application process.

3. The Financial Advisor will obtain the following information from the patient in order to complete the Free Care Application. The information required from the patient to complete the free care application is as follows:

   - Patient W-2 form (tax statement from previous and current year.
   - Three consecutive paystubs from patient's current employment.
   - Dependent information (family size)
   - Any or all bank and checking account statements.

4. The Financial Advisor will refer to the Griffin Hospital sliding scale. This is based on the Federal government Poverty Income Guidelines (see attached sliding scale). The Financial Advisor will make a determination of free care eligibility status.

5. If the patient qualifies for Free Care assistance, the applicable discount percentage will be applied to the patient's account balance.

6. If a patient balance remains, the Financial Advisor will complete one of the following with the patient:

   - require payment in full;
   - set up a monthly payment arrangement.

7. If the patient does not maintain the agreed upon payment schedule, the account will be forwarded to an outside collection agency at the full remaining balance.

8. If a patient does not qualify for Free Care assistance, the Financial Advisor will attempt to:

   - attempt to obtain payment in full;
   - set up a monthly payment arrangement;

9. If a patient does not maintain the agreed upon payment schedule, the account will be forwarded to an outside collection agency at the full remaining balance.

10. If it is later determined by the Griffin Hospital or a collection agency acting on behalf of Griffin Hospital that the patient's financial conditions have changed and the patient was unable to pay the outstanding account balances, an override may be applied by the Business Services Collection Supervisor or Director of Business Services. All overrides will also have to be signed off by the Business Services Collection Supervisor and Business Services Director.

11. The Collection Supervisor will maintain all monthly spreadsheets that will identify all Free Bed funds, Uninsured, and Free Care Assistance allocated on a monthly basis.

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THE GRIFFIN HOSPITAL
BUSINESS OFFICE
STANDARD OPERATING POLICIES

SUBJECT: REMITTANCE REVIEW – CO-PAY FOLLOW UP PROCESS/BAD DEBT

EFFECTIVE DATE: 10/1/2006 SUPERCEDES: 4/2006

RESPONSIBLE DEPT: Business Services APPROVED BY:

Administrator

POLICY:

All patient accounts finalized and processed through the electronic and paper billing processes will be worked by the cash remittance group. If the patient account has a self pay balance, i.e., co-pay, deductible, the account will be worked by the cash analyst to assure the money is moved to the appropriate self pay category.

Accounts having a self pay balance, for all payers excluding Medicare, which have received three data mailers @ a 30 day cycle and have made no payment/ or payment arrangement on the account will be deemed uncollectible and processed for bad debt and forwarded to an outside collection agency. Medicare patients that have a self pay/patient balance will receive four data mailers @ a 30 day billing cycle, and payment or payment arrangement has not been made on the account, the account will be deemed uncollectible and turned over to an outside collection agency.

PROCEDURE:

1. Patient account registered through admissions/registration. All copies of insurance cards are maintained and forwarded to the billing department for review. The billing representative for the assigned payor group will review copy of card and identify billing information policy number as appropriate for billing purposes to carrier.

2. The patient account will be processed for coding through the Medical Records department.

3. Upon coding completion, the account will be finalized and the bill will be produced.

4. The claims will come down and all payor groups will complete a claims edit review.

5. All edits will be completed and entered into the patient account.

6. The claims will be generated either by electronic or manual submission to the assigned payor, i.e., Medicare, Blue Cross, PHS, etc.

7. All electronic claims are downloaded by claim file and transmitted through Web MD and PCACE (Medicare).

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THE GRIFFIN HOSPITAL
STANDARD OPERATING POLICIES

SUBJECT: REMITTANCE REVIEW – CO-PAY FOLLOW UP PROCESS/BAD DEBT

8. All fast EMC edits are completed by the assigned biller.

9. Web MD claims transmitted to Blue Cross

10. All claims that cannot be teleprocessed electronically will be verified and hard copied to the specific insurance carrier.

11. All payers will forward a remittance to the hospital. The remittance will identify those claims paid or denied on accounts and have a remaining balance, i.e., co-pays/deductibles/non-covered services.

12. At this time, all remittances, i.e., Cigna, Aetna/U.S. Health Care, Oxford, Blue Cross, Medicare A & B, State and Saga/State, and Healthnet (PHS) are processed by the cash group. The group will:

    a. Post the payment
    b. Make all necessary adjustments
    c. Identify that a balance remains, i.e., co-pay/deductible and move the money to the appropriate self pay (payor).
    d. Check for secondary insurance information
    e. Make copies of EOB's for secondary review.

15. Upon completion of the remittance review, the account will reflect a true self pay balance, i.e., balance related to deductible, co-pay, self pay (no insurance).

16. If the account reflects a self pay balance, a data mailer will go out.

17. If no payment is made from the first data mailer attempt, a second data mailer will be generated 30 days after. After the patient receives three data mailers (four data mailers for Medicare patients) and no payment has been made, the patient account will be processed into bad debt and will be sent to an external collection agency by the Business Services Collection Supervisor. (see Bad Debt Policy).

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THE GRIFFIN HOSPITAL
BUSINESS OFFICE
STANDARD OPERATING POLICIES

SUBJECT: REMITTANCE REVIEW – CO-PAY FOLLOW UP PROCESS/BAD DEBT

EFFECTIVE DATE: 8/2009 SUPERCEDES: 10/1/2006

RESPONSIBLE DEPT: Business Services APPROVED BY: James J. Maylee Administrator

POLICY:

All patient accounts finalized and processed through the electronic and paper billing processes will be worked by the cash remittance group. If the patient account has a self pay balance, i.e., co-pay, deductible, the account will be worked by the cash analyst to assure the money is moved to the appropriate self pay category.

Accounts that are either a straight self pay or self pay balances after insurance will be referred to an outside agency. The agency will work the patient accounts for all insurance payers for a period of 120 days. If a payment or a payment arrangement is not made to the agency or the hospital within the 120 day time period, the account will be forwarded back to the hospital to the attention of the Collection Supervisor. The Collection Supervisor will forward all accounts returned to an outside collection agency.

PROCEDURE:

1. Patient account registered through admissions/registration. All copies of insurance cards are maintained and forwarded to the billing department for review. The billing representative for the assigned payor group will review copy of card and identify billing information policy number as appropriate for billing purposes to carrier.

2. The patient account will be processed for coding through the Medical Records department.

3. Upon coding completion, the account will be finalized and the bill will be produced.

4. The claims will come down and all payor groups will complete a claims edit review.

5. All edits will be completed and entered into the patient account.

6. The claims will be generated either by electronic or manual submission to the assigned payor, i.e., Medicare, Blue Cross, PHS, etc.

7. All electronic claims are downloaded by claim file and transmitted through Web MD and PCACE (Medicare).

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THE GRIFFIN HOSPITAL
STANDARD OPERATING POLICIES

SUBJECT: REMITTANCE REVIEW – CO-PAY FOLLOW UP PROCESS/BAD DEBT

8. All fast EMC edits are completed by the assigned biller.

9. Web MD claims transmitted to Blue Cross

10. All claims that cannot be teleprocessed electronically will be verified and hard copied to the specific insurance carrier.

11. All payers will forward a remittance to the hospital. The remittance will identify those claims paid or denied on accounts and have a remaining balance, i.e., co-pays/deductibles/non-covered services.

12. At this time, all remittances, i.e., Cigna, Aetna/U.S. Health Care, Oxford, Blue Cross, Medicare A & B, State and Saga/State, and Healthnet (PHS) are processed by the cash group. The group will:

    a. Post the payment
    b. Make all necessary adjustments
    c. Identify that a balance remains, i.e., co-pay/deductible and move the money to the appropriate self pay (payor).
    d. Check for secondary insurance information
    e. Make copies of EOB's for secondary review.

15. Upon completion of the remittance review, the account will reflect a true self pay balance, i.e., balance related to deductible, co-pay, self pay (no insurance).

16. If the account reflects a self pay balance, the account will be referred to an outside agency to obtain payment or enter the account into a payment plan. If no payment or payment arrangement is made by the patient within the 120 day time frame, the account will be sent back to the hospital. All accounts forwarded back to the hospital will be sent to an outside collection agency by the hospital Collection Supervisor.

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GRIFFIN HOSPITAL SLIDING SCALE
FOR INSURED PATIENTS HAVING COPAY AND DEDUCTIBLE PATIENT BALANCES FEBRUARY 2009

	of 250% HHS Poverty Income guidelines:	of 280% HHS Poverty Income guidelines:		of 310% HHS Poverty Income guidelines:		of 340% HHS Poverty Income guidelines:		of 370% HHS Poverty Income guidelines:		of 400% HHS Poverty Income guidelines:	
	100 % FREE CARE	85 % FREE CARE		75 % FREE CARE		50% FREE CARE		35 % FREE CARE		30% FREE CARE	
		15%-PATIENT SHARE		25% PATIENT SHARE		50% PATIENT SHARE		65% PATIENT SHARE		70% PATIENT SHARE	
Size of Family	Income Within	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To
1	0 –27,075	27,076	30,324	30,325	33,573	32,241	36,822	36,823	40,071	40,072	43,320
2	0-36,425	36,426	40,796	40,797	45,167	45,168	49,538	49,539	53,909	53,910	58,280
3	0-45,775	45,776	51,268	51,269	56,761	56,762	62,254	62,255	67,747	67,748	73,240
4	0-55,125	55,126	61,740	61,741	68,355	68,356	74,970	74,971	81,585	81,586	88,200
5	0-64,475	64,476	72,212	72,213	79,949	79,950	87,686	87,687	95,423	95,424	103,160
6	0-73,825	73,826	82,684	82,685	91,543	91,544	100,402	100,403	109,261	109,262	118,120
7	0-83,175	83,176	93,156	93,157	103,137	103,138	113,118	113,119	123,099	123,010	133,080
8	0-92,525	92,526	103,628	103,629	114,731	114,732	125,834	125,835	136,937	136,938	148,040

1. Source: Federal Register, Vol.743, No. 14, January 23, 2009, PP. 3971-3972
2. For family size with more than eight (8) MEMBERS, add $3,740 for each additional member.
3. This sliding scale is based on the 2009 HHS Poverty guidelines for the 48 contiguous states and the District of Columbia.

Effective 02/01/?

2009 HHS POVERTY INCOME GUIDELINES (UNCOMPENSATED FREE CARE PROGRAM)
EFFECTIVE : FEBRUARY 2009

UNINSURED SLIDING SCALE

Determination Codes	100% IF LESS THEN 250% OF HHS POVERTY INCOME GUIDELINES	85% IF at 280% OF HHS poverty income guidelines		75% If at 310% of the HHS POVERTY INCOME GUIDELINES		50% If at 340% of the HHS POVERTY INCOME GUIDELINES		35 % If at 370% of the HHS POVERTY INCOME GUIDELINES		400% of the HHS POVERTY INCOME GUIDELINES 30%
Size of Family	Income Within	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To	
1	0 – 27,075	27,076	30,324	30,325	33,573	33,574	36,822	36,823	40,071	43,320
2	0 - 36,425	36,426	40,796	40,797	45,167	45,168	49,538	49,539	53,909	58,280
3	0 -45,775	45,776	51,268	51,269	56,761	56,762	62,254	62,255	67,747	73,240
4	0 -55,125	55,126	61,740	61,741	68,355	68,356	74,970	74,971	81,585	88,200
5	0 -64,475	64,476	72,212	72,213	79,949	79,950	87,686	87,687	95,423	103,160
6	0 - 73,825	73,826	82,684	82,685	91,543	91,544	100,402	100,403	109,261	118,120
7	0 - 83,175	83,176	93,156	93,157	103,137	103,138	113,118	113,119	123,099	133,080
8	0 - 92,525	92,526	103,628	103,629	114,731	114,732	125,834	125,835	136,937	148,040

This sliding scale encompasses the Free Care assistance program for all services.

For family size with more than eight (8) members, add $ 3,740 for each additional member.

GRIFFIN HOSPITAL 2009 POVERTY INCOME GUIDELINES– DETERMINATION SCALE
UNINSURED PATIENTS

	Uninsured - Poverty Income Guidelines Federal 2009			
Size of Family	Income Within	200%	250%	400%
1	10,830	21,660	27,075	43,320
2	14,570	29,140	36,425	58,280
3	18,310	36,620	45,775	73,240
4	22,050	44,100	55,125	88,200
5	25,790	51,580	64,475	103,160
6	29,530	59,060	73,825	118,120
7	33,270	66,540	83,175	133,080
8	37,010	74,020	92,525	148,040

- Care should be provided free for those uninsured patients who request assistance and Verify their annual income is less than 200% of the Federal Income Poverty Level (FPL).
- Care should be provided at hospital cost,as established by the Office of Health Care Access (OHCA), for those uninsured patients who request assistance and verify their Annual income is between 200% and 250% of the FPL.
- Care should be discounted by 30 % for those uninsured patients who request assistance And verify their annual income is between 250% and 400% of the FPL.

Effective February 2009

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GRIFFIN HOSPITAL SLIDING SCALE
FOR INSURED PATIENTS HAVING COPAY AND DEDUCTIBLE PATIENT BALANCES FEBRUARY 2008

Determination Codes											
	of 250% HHS Poverty Income guidelines:	of 280% HHS Poverty Income guidelines:		of 310% HHS Poverty Income guidelines:		of 340% HHS Poverty Income guidelines:		of 370% HHS Poverty Income guidelines:		of 400% HHS Poverty Income guidelines:	
	100 % FREE CARE	85 % FREE CARE		75 % FREE CARE		50% FREE CARE		35 % FREE CARE		30% FREE CARE	
		15%-PATIENT SHARE		25% PATIENT SHARE		50% PATIENT SHARE		65% PATIENT SHARE		70% PATIENT SHARE	
Size of Family	Income Within	Greater Than	Up To	Greater Than	Up To	Greater Than*	Up To	Greater Than	Up To	Greater Than	Up To
1	0 –26,000	26,001	29,120	29,121	32,240	32,241	35,360	35,361	38,480	38,481	41,600
2	0-35,000	35,001	39,200	39,201	43,400	43,401	47,600	47,601	51,800	51,801	56,000
3	0-44,000	44,001	49,280	49,281	54,560	54,561	59,840	59,841	65,120	65,121	70,400
4	0-53,000	53,001	59,360	59,361	65,720	65,721	72,080	72,081	78,440	78,441	84,800
5	0-62,000	62,001	69,440	69,441	76,880	76,881	84,320	84,321	91,760	91,761	99,200
6	0-71,000	71,001	79,520	79,521	88,040	88,041	96,560	96,561	105,080	105,081	113,600
7	0-80,000	80,001	89,600	89,601	99,200	99,201	108,800	108,801	118,400	118,401	128,000
8	0-89,000	89,001	99,680	99,681	110,360	110,361	121,040	121,041	131,720	131,721	142,400

1. Source: Federal Register, Vol. 73, No. 15, January 23, 2008, PP. 3971-3972
2. For family size with more than eight (8) MEMBERS, add $3,600 for each additional member.
3. This sliding scale is based on the 2008 HHS Poverty guidelines for the 48 contiguous states and the District of Columbia.

Effective 02/01/200

2008 HHS POVERTY INCOME GUIDELINES (UNCOMPENSATED FREE CARE PROGRAM)
EFFECTIVE : FEBRUARY 2008

UNINSURED SLIDING SCALE

Determination Codes	100% IF LESS THEN 250% OF HHS POVERTY INCOME GUIDELINES	85% IF at 280% OF HHS poverty income guidelines		75% If at 310% of the HHS POVERTY INCOME GUIDELINES		50% If at 340% of the HHS POVERTY INCOME GUIDELINES		35 % If at 370% of the HHS POVERTY INCOME GUIDELINES		400% of the HHS POVERTY INCOME GUIDELINES 30%
Size of Family	Income Within	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To	
1	0 –26,000	26,001	29,120	29,121	32,240	32,241	35,360	35,361	38,480	41,600
2	0 –35,000	35,001	39,200	39,201	43,400	43,401	47,600	47,601	51,800	56,000
3	0 – 44,000	44,001	49,280	49,201	54,560	54,561	59,840	59,841	65,120	70,400
4	0 – 53,000	53,001	59,360	59,361	65,720	65,721	72,000	72,001	78,440	84,800
5	0 – 62,000	62,001	69,440	69,441	76,880	76,881	84,320	84,321	91,760	99,200
6	0 –71,000	71,001	79,520	79,521	88,040	88,041	96,560	96,561	105,080	113,600
7	0 – 80,000	80,001	89,600	89,601	99,200	99,201	108,800	108,801	118,400	128,000
8	0 –89,000	89,001	99,680	99,681	110,360	110,361	121,040	121,041	131,720	142,400

This sliding scale encompasses the Free Care assistance program for all services.

GRIFFIN HOSPIITAL 2008 POVERTY INCOME GUIDELINES– DETERMINATION SCALE
UNINSURED PATIENTS

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Determination Codes				
	Uninsured - Poverty Income Guidelines Federal 2008			
Size of Family	Income Within	200%	250%	400%
1	10,400	20,800	26,000	41,600
2	14,000	28,000	35,000	56,000
3	17,600	35,200	44,000	70,400
4	21,200	42,400	53,000	84,800
5	24,800	49,600	62,000	99,200
6	28,400	56,800	71,000	113,600
7	32,000	64,000	80,000	128,000
8	35,600	71,200	89,000	142,400

- Care should be provided free for those uninsured patients who request assistance and Verify their annual income is less than 200% of the Federal Income Poverty Level (FPL).
- Care should be provided at hospital cost,as established by the Office of Health Care Access (OHCA), for those uninsured patients who request assistance and verify their Annual income is between 200% and 250% of the FPL.
- Care should be discounted by 30 % for those uninsured patients who request assistance And verify their annual income is between 250% and 400% of the FPL.

Effective
February
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